ALCOHOL ADDICTION

Toward a More Comprehensive Definition

Norman E. Zinberg

Dynamic Approaches to the Understanding and Treatment of Alcoholism

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About the Author

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Alcohol Addiction: Toward a More Comprehensive Definition[1]

Norman E. Zinberg

The use of alcohol in the United States is more significant and widespread than most Americans admit. The excessive use of alcohol, or alcoholism, is one of the most prevalent and difficult problems facing our society and our clinicians. Various groups of professionals in the field—physicians, psychiatrists, psychologists, epidemiologists, social workers, lawyers—see this problem from their own perspective and base their treatment strategies on that perspective. So far the experts have neither achieved a common definition of alcoholism nor constructed a comprehensive model that describes in a unified way the etiology (causes), motivation, and operation of problem drinking. Each of these professional groups takes only a partial view of this phenomenon, and all of them overlook the role which the social setting—the drinker's family, peer group, and society—plays in the development and perpetuation of his problem. Although no cure for alcoholism has been discovered, the most successful treatment is provided by Alcoholics Anonymous, which requires complete abstinence. That the drinker's social setting is an essential factor is shown by A.A.'s insistence that the alcoholic join its community and obey its social sanctions and rituals.

This chapter, which focuses on the etiology and treatment of problem drinking, will present a comprehensive or multivariate interpretation of alcoholism based on a combination of the three major current models and including the alcoholic’s social setting. Case studies will illustrate the clinician’s need for this comprehensive approach in order to understand and treat effectively each individual who wants to work on the problem.

Importance of Alcohol in the American Culture

In psychological circles Freud’s famous comment that the two most important investments of human energy are “to love and to work” remains unchallenged. Our preoccupation with these two activities, sex and the capacity to gain self-esteem and economic viability through work, is obvious. Of the three other major human concerns not mentioned by Freud—food, intoxicants, and religion—only religion is consciously accepted as a vital concern on a par with love and work; but in our increasingly secularized culture, religion consumes far less psychic energy than either eating or drinking. Yet for some obscure moral reason dating back to our Puritan or Victorian or temperance-movement ancestors, our preoccupation with eating and drinking is minimized by society and suppressed by the individual.

A preoccupation with food is of course justifiable as necessary for survival. Sometimes this preoccupation may even develop into an art. But the

extent to which we think about, plan, anticipate, or dread eating is rarely discussed openly. And in this culture the extent of interest in intoxicants, principally alcohol, is acknowledged even less than the interest in food. We play down the prevalent daily interest in alcohol by narrowly focusing attention on the alcoholic, the problem drinker, the alcohol addict—in other words, the person in trouble because of alcohol. By concentrating thus on the troubled alcohol user, most Americans suppress their constant need to make socially important decisions about whether to drink, when to drink, with whom to drink, and how much to drink.

Nevertheless, the issue of alcohol use affects us all. Demography suggests that only a fraction of drinkers are alcoholics, but to conclude from population statistics that the American culture is comfortable with alcohol is to ignore the substantial role that this drug plays in the lives of both social drinkers and abstainers.

Most of us drink. Even those of us who do not use what the colonists called "God's gifte to Man" (Kohler, 1973; Krout, 1925) and what the temperance movement dubbed "Demon Rum" are forced to give frequent if not daily consideration to the issue of alcohol consumption. Although both nondrinkers and cocktail-party habitués would protest if it were suggested that abstinence or social drinking gives them difficulty, the use or nonuse of the "neutral spirit" (Roueche, 1960) involves more than an initial

postadolescent decision to drink or not to drink.

The “drink or abstain” decision is made not once but thousands of times in a lifetime. It is in fact a continuum of decisions complicated by the ubiquity of alcohol in this culture and the ambiguous mores surrounding its use. Even for the abstainer, who has presumably made a “once and for all” decision about alcohol, life presents numerous social and business occasions on which he is required to defy what amounts to a social convention, on which it would be easier to accept a drink, and on which nondrinkers and ex-drinkers alike must explain why alcohol is an issue in their lives. For the drinker, the questions of when, how much, and with whom to drink constantly present themselves and require energy-consuming decisions. For instance, while the drinker knows that a six- pack of beer is acceptable at a noontime football game in October, he is less certain how many beers are permissible at a company picnic on a July morning, or at a cocktail party on the boss’s boat, or with a client at lunchtime.

Like sex, work, religion, and food, the daily behavioral issue of alcohol consumption is a matter of personal decision influenced by the individual’s constitution and history and by the dictates of the immediate social context. Coping with it is a task made difficult not only by the appeal of the drink at hand but by the ambiguities of the social setting. Maddox has suggested that “Americans drink with a certain sadness” (1970), a sadness probably rooted

in their culturally derived ambivalence toward the social and individual character of drinking. This cultural ambivalence has been forged and reforged during each historical period, each social and economic upheaval, and each era of immigrant assimilation (Sinclair, 1962). The resulting negation of alcohol use has led to a curious worship of abstinence, which is little practiced and, when practiced, little respected. Heilman (1975) discusses this lack of respect for actual abstinent behavior which, when combined with the worship of abstinence, results in the laws regulating alcohol consumption forming a crazy-quilt pattern that would not be tolerated in any other area of jurisprudence. These laws are accepted because of the unspoken moral dictum that we really should not be using alcohol at all. Heilman goes on to demonstrate conclusively that this would not be tolerated in any other area of jurisprudence. This abstinence orientation has made it difficult to acknowledge the advantages inherent in the use of intoxicants and has mistakenly set up the abstainer as a model of moral strength. This attitude has affected our treatment strategies, spread confusion about what we want to prevent, and led to unfortunate theoretical oversimplifications concerning the causes of drinking.

Definitions of Alcoholism

The refusal to recognize the widespread interest in alcohol in the United States may be a key factor in the frequent failure of clinicians to distinguish

between two basically different types of alcohol users: the heavy drinker who will never become an alcoholic and the problem drinker who is actually in an early phase of alcoholism. Clinicians must have a clear understanding of what alcoholism is in order to tell the difference between these two types of drinkers.

Because the professional community has not been able to reach agreement on such a definition, clinicians are faced, as Mark Keller points out in a concise and brilliant article (1962), with at least five definitions proposed by experts from as many different fields: medicine; pharmacology; the behavioral sciences; medicine, psychiatry, and psychology combined; and learning theory. Each definition expresses only the view of the field from which it originates.

Whereas the old-fashioned medical view defines alcoholism as “a disease caused by chronic excessive drinking” (Keller, 1973), pharmacology classifies it as a drug addiction marked by the need to increase doses to produce the desired effect and by a withdrawal syndrome if alcohol is not available.

The behavioral definition describes alcoholism as a disease of unknown cause without recognizable anatomical signs, manifested by addiction or dependence on alcohol. The combined psychological, psychiatric, and medical

definition states that alcoholism may be a disease in its own right or the symptom of another underlying, possibly psychological disease; in the first case it is in itself a chronic and usually progressive illness, while in the second case it is symptomatic of an underlying psychological or physical disorder characterized by (1) dependence on alcohol for the relief of psychological or physical distress or for the gratification resulting from intoxication, and (2) the consumption of alcoholic beverages in sufficient quantities and with sufficient consistency to cause physical, mental, social, or economic disability. Finally, the definition based on learning theory describes alcoholism as a learned (or conditioned) dependence upon (or addiction to) alcohol that irresistibly activates drinking behavior whenever a critical or internal or environmental stimulus (or cue) presents itself (Keller, 1973).

As Mark Keller makes clear, each of these five definitions has its limitations as well as its merits. Reflecting the view of its field of origin, each fails to satisfy the needs of all the other experts concerned with alcohol problems, such as the epidemiologist, the sociologist, and the lawyer. Epidemiologists, who need to identify whole populations that are not available for individual examination, must rely on quantity-frequency measures and on statistical reports of other injurious conditions known to be alcohol-related. Sociologists need to identify drinkers whose behavior deviates sufficiently from the customary social or dietary use of alcohol in the drinker's community to be considered a problem. Thus they are interested in

the drinker's arrest rate, hospitalization, and clinical diagnosis, in whether he has defined himself as a deviant by joining A.A., and in how he is viewed by the community. Lawyers have still other needs: to judge whether an individual under the influence of alcohol is a threat to the public welfare and to decide whether he is a danger to the health, welfare, and competence of himself and others.

Because it deals with the causes and treatment of alcoholism, this chapter is more concerned with the needs of the clinician than with those of the other professionals in the field. From the clinician's point of view, these five rather superficial definitions leave much to be desired. For one thing, they do not distinguish between genuine alcoholism on the one hand and heavy drinking on the other, for they fail to take into account the duration and extent of drinking. That omission becomes particularly significant in relation to drinkers who have severe but time-limited bouts with alcohol. While such bouts, accompanied by job loss and auto accidents, certainly are indications of a serious disturbance, it is doubtful whether they can be classified as alcoholism if they are indeed time- limited and nonrecurrent. This same ambiguity poses a problem even for those who do not regard alcoholism as a disease in its own right, but rather as the symptom of an underlying psychological disorder.

The five definitions have still other limitations for the clinician. The

medical view, which simply regards alcoholism as a disease that results from drinking, does not attempt to spell out precursors, factors of causal significance, or degree. Similarly, the pharmacological definition fails to account for the many drinkers who either never show withdrawal symptoms or do so inconsistently, sometimes severely and sometimes not at all. (It must be remembered that tolerance to alcohol does not continue to develop until it approaches the lethal dose, as in the case of the opiates; at various stages of drinking there may in fact be an actual decrease in tolerance.) The strict behavioral view of alcoholism as an addiction or dependency suffers from the existence of individual differences in the signs and symptoms that follow large intakes of alcohol. The more comprehensive medical-psychological definition gives disablement of some kind as evidence of alcoholism, but some extremely heavy drinkers do not show any of the classical disabilities. Moreover, by not referring to a genetic component, this definition excludes the possibility of genetic or genetotrophic causal factors. Learning theorists have not been able to prove that drinking is actually triggered by specific stimuli or cues because often the drinking is either continuous or too erratic to contribute validity to the idea that a specific stimulus operates in a specific situation. In addition, the tendency to rely on the drinker's own assessment of the extent of his problem is far from helpful: some genuine alcoholics deny that they are alcoholics and prefer to be seen as neurotics, while some neurotics prefer to attribute their responses to what is essentially a

nondestructive intake of alcohol.

In our society, where the importance of alcohol use is underestimated and there is no agreement on a common definition of alcoholism, it is not surprising that each professional group continues to cling to the definition that suits its particular purpose. But something beyond a series of disparate definitions is needed to illuminate the causes of alcoholism and enable clinicians to treat it successfully. During the past thirty years or so valuable insights have come from three views or models of alcoholism: the modern medical and biomedical, the genetic or genetotrophic, and the psychosocial. These models go beyond simple definitions, beyond what alcoholism "is," and provide comprehensive views that include also the causes or motivational factors (etiology), the process through which the phenomenon operates, and the types of treatment that are likely to be most effective in coping with it.

Three Models of Alcoholism

Medical and biomedical. The medical model is made up of three components: an infectious or toxic agent, a host, and a specific degenerative response resulting from the interaction of agent and host. This model has a long history, beginning with the medical definition of alcoholism already discussed. Since about 1800, prolonged drunkenness has been recognized as an "odious disease," to use Benjamin Rush's term (Kobler, 1973). From then

until 1950, the physician's view was made up of rough generalizations expressing his medical and moral distaste for alcoholism. E. M. Jellinek, acting at the behest of the World Health Organization, took these generalizations and defined alcoholism as a specific medical entity (Jellinek, 1960; Kobler, 1973). His early formulations envisaged three phases of development: (1) “symptomatic drinking,” which preceded the development of the disease; (2) “addictive drinking,” in which some irreversible change took place which might have a physical basis, possibly of a constitutional nature, and which marked the onset of the disease; and (3) the “organic complications” phase. The elusive semantic problems inherent in Jellinek’s formulation have plagued the field ever since, raising the unanswerable question “Is the disease the result of drinking or its cause?”

If it were possible to define alcoholism as the exclusive result of the interaction between a toxic agent (alcohol) and a human host, there would be no problem. But such a simplistic view of interaction ignores both the genetic and psychosocial aspects of the disease. It does not make clear that defects of a constitutional and a psychological nature—a preexisting disability, a virtual allergy, or a preexisting personality disturbance—are diseases in their own right rather than only part of the “disease” of alcoholism. Nor does it take account of the fact that changes in the social setting—the mores, values, and attitudes of the larger culture or of smaller social groups—crucially affect the extent of alcoholism as well as its development in particular individuals.

In the 1960s the advent of Antabuse (disulfiram) buttressed the validity of the medical model. Here was a genuine treatment, a way to neutralize the toxic agent. Now a drug could be prescribed, just as penicillin could be prescribed for conditions caused by the pneumonia bacteria, although obviously the mechanisms were vastly different.

In some cases the prescribing of Antabuse was done in the same strict medical sense. Generally, however, motivating the host (the drinker) to take medicine to neutralize the agent (alcohol) responsible for his “disease” proved a formidable task, whereas pneumonia patients rarely refused the use of penicillin as an antidote to their disease. Thus, while Antabuse could be a useful adjunct to the treatment of an alcoholic personally committed to recovery, it could not usually be the key treatment factor. Persuading the alcoholic to take a stand against his wishes to drink remained the crucial aspect of any treatment and did not easily fit the strict medical model.

The search for a valid medical-disease model has gradually taken a new direction, shifting to the biomedical study of physiology in the hope that some defect in the body's way of handling alcohol can be shown to be the cause of alcoholism. Here, too, however, the same question must be asked: ‘is the disease the result of drinking or its cause?” Because most biomedical studies have been done on animals or humans who have ingested excessive quantities of alcohol, it is not clear whether the findings are innate or

acquired.

The physiological mechanisms that might result in the development of alcohol dependency have been widely studied. Joseph Cochin (1966) of Boston University, for one, has posited four possible mechanisms: (1) altered metabolic disposal of the drug (alcohol); (2) blockade of the drug from its usual active site; (3) occupation and saturation of the site by the drug; (4) cellular adaptation to the drug resulting from biochemical transformation of the metabolic activity of the cell. All these mechanisms refer to an alteration in cellular or site activity which results in functional impairment when the drug is not used. Goldstein and Goldstein (1961), to take another example, have formulated an extremely complex hypothesis regarding the possibility of the enzyme system which regulates in inverse ratio its product. The drug inhibits the enzyme system so that less product is formed, thus permitting the formation of greater amounts of the enzyme whose activity is balanced by the inhibitory effect of the alcohol. If alcohol is removed, the enzyme effect is unchecked and a withdrawal syndrome results. Unfortunately, not Cochin's or the Goldsteins' or any other attempt to account for the acknowledged physical dependency on alcohol specifies whether what happens to the body is exclusively the result of alcohol intake or whether it expresses preexisting potentialities. The same conundrum is inherent in the other well-known biochemical effects of alcohol, such as those occurring on the release of catecholamine or indoleamine.

The difficulty in constructing a biomedical model for the development of alcoholism is partly due to the existence of great individual differences in both the body's handling of alcohol and the effect of long-term excessive intake. It also stems from the inherent toxicity of alcohol, as indicated by the limited development of alcohol tolerance, which is likely to cause severe physiological changes.

So far the medical-disease concept has been most useful to Alcoholics Anonymous. A. A. bypasses the semantic problems of the medical definition and uses the disease concept of alcoholism as the cornerstone of its program, thereby alleviating the dreadful guilt of the alcoholic. By calling attention to his helplessness in the face of this disease, A. A. modifies his guilt and justifies the need to call on a higher power for help in the struggle for sobriety. Even this loose symbolic notion of disease has aroused controversy, however. Keller (1973) points out that calling alcoholism a disease gives the alcoholic an excuse for his drunkenness, reinforces his dependence, and shifts responsibility to the medical profession. which is usually unable to deal with the condition.

A.A. pays little attention to the question of whether the "disease" precedes alcoholism or. as Jellinek suggests (1960), results from the excessive drinking. The A.A. disease concept is purely heuristic, intended to exemplify the helplessness over drinking experienced by the alcoholic and to separate

attempts to work with the uncontrolled alcoholic as he is—lost, alone, in poor health—from attempts to work with him by trying to reconstruct those issues —medical, psychological, or social— that may be instrumental in his being as he is. According to the A.A. credo, the alcoholic must be worked with as he is. While there is some evidence that this is clinically effective when working with the long-term deteriorated drinker, the A. A. concept of disease should not be confused with the more specific strict medical models described by Cochin (1966) or by Goldstein and Goldstein (1961). An important emphasis in this chapter is to point out that the effectiveness of A. A. for its members may vary according to how the condition of alcoholism is defined. Elsewhere we (Zinberg & Fraser, 1979) have considered whether the psychological factors that enable A.A. to be successful with hard-core alcoholics may be detrimental to efforts toward prevention of alcoholism or to work with drinkers who are in early stages of difficulty.

Genetic and genetotrophic. The genetic model, which bases the development of alcoholism on some specific birth defect, is closely related to the medical or physiological model. It simply shifts the "disease" or the defect in functioning that prepared the way for alcoholism back to an earlier time in the development of the individual. In 1974 E. M. Pattison suggested that ideological factors (such as racial discrimination) rather than scientific concerns accounted for the continued focus on physiological theories, particularly on the notion of the possible genetic factors. This emphasis on

being inherently defective is congruent with the alcoholic's own preoccupation that his inability to drink successfully represents some sort of inherent defect. In positing an underlying biological defect as the cause of alcoholism, these theories are consistent with the disease model, justifying medical intervention, providing an effective defense rationale for those who suffer from the condition (e.g., “I have an illness”), and. most important of all, holding out the promise of a discoverable medical cure.

One of the first genetic theorists was R. J. Williams, who in 1947 approached the possibility of an inherent metabolic defect by considering individuals whose metabolic makeup dictated the consumption of certain nutrients in amounts far in excess of the quantities present in a “normal” diet. Assuming that the consumption of alcohol alleviated symptoms of deficiency but did not provide needed nutrients, he hypothesized the existence of an alcoholic “vicious cycle” resulting from the afflicted individual’s attempt to relieve unpleasant symptoms with increasing amounts of alcohol, which in turn led to alcohol addiction without relieving the original deficiency. Williams’s theory of alcoholism, as well as similar theories about the nutritional use of alcohol by individuals with aberrant metabolism (Williams, 1959), has been refuted empirically by a number of experimenters (Lester, 1960; Mardones, 1951; Popham, 1947; Randolph, 1956).

Another area which for a time offered hope of finding a genetic root for

alcoholism was endocrine dysfunction. Hypoglycemia, for example, was cited as a symptom from which alcohol could offer temporary relief by raising the level of blood sugar. Long-term dependence upon alcohol was also seen as overmedication by the individual who ingested progressively larger amounts to cope with the (reverse) effects of alcohol itself. There is a famous Orson Welles movie (Touch of Evil, 1958) in which he, large as a mountain, continuously munches on candy bars. When Marlene Dietrich, who remembers him in his younger, more handsome days, says, “You better lay off the candy bars,” Welles replies, “Better than the hooch.” Although that passage could be interpreted by proponents of psychological theories as an indication of the need for oral gratification, it underscores how strong in the popular imagination is the notion that some form of nutriment, alcohol or a replacement, may be needed to quell powerful inborn fires. Similar reasoning led C. P. Richter in 1956 to report an association between alcoholism and congenital hypothyroidism. Little empirical evidence has emerged, however, to support the endocrine dysfunction point of view.

Until recently, in spite of the appeal of the genetic model to some students of alcoholism, its validity, as Pattison pointed out, seemed to rest on an ideological rather than a scientific basis. In fact, the effort to attribute the frequency of alcoholism among American Indians to a genetic rather than a psychosocial component was attacked as frank racism: just one more way of characterizing that minority group as inherently defective. In 1973, however,

as a result of the tenacity of investigators and superb record keeping by the Danish government, evidence emerged which indicates that there is indeed a propensity for alcoholism in some individuals and some families that cannot be explained on a psychosocial basis (Goodwin & Guze, 1974; Goodwin et al., 1973; Schuckit et al., 1972).

The basic study, begun in the 1940s, was made of Danish twins, one of whom was adopted and the other raised by the birth family. This and other carefully controlled studies that followed show that children of alcoholic heritage are more likely to exhibit alcoholism than are children whose adoptive parents are alcoholic. That is, children whose birth families show alcoholism will develop alcoholism more readily when placed with families that have no alcoholism than will children whose birth families do not show alcoholism. And conversely, children whose birth families do not show alcoholism are less likely to develop alcoholism when adopted into alcoholic families than are children who are both born and raised in alcoholic families.

In addition, there are other studies which, taken separately, do not provide conclusive evidence for a genetic link in certain cases of alcoholism, but which, in combination, do provide considerable support for it. McLearn and Rodgers (1959) and Rodgers (1966) found and explored an inherited preference for alcohol in certain strains of mice. Wolff (1972) discovered that the “flushing” response to alcohol in certain human racial strains probably

indicates an inborn response. Cruz-Coke (1964) and Camps and Dodd (1967) documented the association between alcoholism and assumed inherited characteristics ("genetic markers"), while Winokur et al. (1970) were able to provide clear documentation of alcoholism in certain families.

Although the Danish twin studies and the other studies just mentioned indicate strongly that a genetic factor exists in certain cases of alcoholism, the available statistical correlations have been developed from a very small fraction of the total number of alcoholics. Thus they do not show that all cases or even most cases of alcoholism have a genetic component. Moreover, little or no evidence exists concerning the mechanisms of the inheritance of susceptibility to alcohol addiction. In 1945 E. M. Jellinek characterized the problem of the role of genetics as a question of the interplay of social and cultural factors with an inherited "breeding ground" for alcoholic behaviors and illnesses. But researchers since that time have been able to add only limited empirical data to his theoretical suggestion.

Psychosocial. Most of the work done on the etiology and treatment of alcoholism during the past thirty years or so has centered on the psychosocial model. This is an enormous area, including all the psychological, social, and economic causes and components of problem drinking. It is the field studied not only by the psychologist and psychiatrist but by the social historian, anthropologist, sociologist, and economist. It includes such topics as (1) the

vulnerability of particular personality types and the influence of child-rearing patterns; the differing attitudes and customs surrounding alcohol use (2) in America at different historical periods, (3) in primitive cultures, and (4) in different ethnic groups; and (5) the impact of widely varying economic circumstances.

First, the psychological theory that difficulty in handling alcohol is rooted in the personality of the individual and based on conflicts and deprivations experienced in his early relationships with his parents or significant others began to take hold very shortly after Sigmund Freud developed the theory of psychoanalysis. Alcoholism was, after all, a profound and obvious behavioral disorder which brought great pain to the sufferer, to those around him, and even to his society. Any theory purporting to understand the aberrations of the human psyche could hardly ignore it. And the ability of this powerful and comprehensive theory to explain so many things that had formerly been seen as vices, curses, or physiological disturbances caused by long-buried, unbearable affects within the individual himself led to high hopes that psychoanalysis would illuminate the mysteries of alcoholism.

At first sight, the problem of alcoholism seemed transparent to the psychoanalytic theorist. The drunk's attachment to a fluid container, his inability or unwillingness to care for himself, and his unending self-

castigation when sober seemed the very epitome of unresolved oral wishes. To conceptualize those symptoms in terms of an early unresolved attachment to the mother and her breast, to see the unwillingness to care for oneself as the expression of a wish to return to infancy, and to interpret the ensuing depression as a sense of inner emptiness and a guilt about the greedy wish to fill it fitted neatly into the early discovery of the "id" with its unconscious wishes and concerns.

People with such unresolved oral wishes do indeed exist, and some of them become alcoholics. And there are accounts of the successful treatment of such people by psychoanalysis or by the various allied dynamic psychotherapeutic techniques. As the studies of alcohol use progressed, however, it became increasingly clear that in certain individuals the phenomenon was far too complex to be explained solely through early conflicts. Also, the direct psychiatric treatment of alcoholics was not successful enough to generate much confidence in that approach. But most sophisticated psychologists continued to believe that certain early child-rearing experiences, relationships to key figures, or early deprivations might become a "breeding ground," or area of potential vulnerability, in an individual if other alcoholism-inducing social and psychological circumstances were also present.

Second, as for the social and cultural aspects of the psychosocial model,

we described in an earlier paper (Zinberg & Fraser, 1979) the differing social attitudes toward alcohol use that characterized five main periods of American history: the colonial period, the Revolutionary and post-Revolutionary era, the nineteenth century, the prohibition era, and the period after repeal.

The American colonists, who firmly believed in the medical and spiritual benefits of regular drinking, virtually soaked themselves in alcohol. However, because they had powerful rules concerning quantity of consumption and acceptable deportment, they were able to control the use of alcohol and contain drunkenness.

During the Revolutionary War, when the government used liquor to encourage men to fight, a basic change seems to have occurred in the social view of alcohol. After the war its use and manufacture rapidly became commercialized: men began to drink large quantities of manufactured hard liquor in taverns owned by businessmen who were more concerned with profits than deportment.

Early in the nineteenth century the advent of the Industrial Revolution, which split families, opened frontiers, and created quite different social standards from those of the pre-Revolutionary colonists, introduced an era of excessive alcohol use. During this time drunkenness abounded, the rate of alcoholism grow, and alcohol consumption tended to lead to violence. By the

end of the nineteenth century, however, markedly greater control over alcohol again began to be the norm. Saloons became family gathering places rather than hangouts for lonely and angry men and for prostitutes, and their provision of a free lunch reintroduced the idea that drinking should be associated with eating.

Ironically, the prohibition movement, whose origins earlier in the nineteenth century had been based on firm figures concerning the terrible consequences of uncontrolled alcohol use, became more shrill, more moralistic, and much more politically successful at the very time when the ways in which alcohol was being used had begun to improve. By the time the federal Volstead Act was passed, twenty-one states were already dry. In effect prohibition ushered in another era of excess, centered in the speakeasies. Speakeasies were not family places; they were associated with illegality and violence and rarely served food. While *The Untouchables*, the popular television series about revenue agents, was a tremendous exaggeration, its success symbolized the extent to which alcohol use was linked to gangsterism, immorality, and corruption. Also and perhaps most important, prohibition once again changed drinking patterns. The casual drinker did not go to the risk and trouble of seeking out a speakeasy just to buy a glass of beer. All too often the people who went to speakeasies went there to get drunk.

The repeal of prohibition was greeted with a degree of rejoicing that made the customary New Year's Eve celebration seem like a damp firecracker. The period after repeal was very wet indeed. Alcohol use increased every year until 1965. From then until 1978, the year for which the latest firm figures are available, there was some fluctuation in use, though the rate of use has remained relatively stable since 1974 or 1975. There are five conditions that cross-cultural researchers have found to be correlated in most societies with nonabusive drinking practices and low rates of alcoholism. The slow progress made through the 1970s in attaining a relatively high degree of social control over alcohol use seems to be based on the increased acceptance of these five conditions:

1. Group drinking is clearly differentiated from drunkenness and associated with ritualistic or religious celebrations. Historically, one way of strengthening this stricture has been the group's participation in the preparation of the alcoholic beverage consumed.

2. Drinking is associated with eating, preferably ritualistic feasting.

3. Both sexes and several generations are included in the drinking situation, whether all drink or not.

4. Drinking is divorced from the individual's effort to escape personal anxiety or difficult (intolerable) social situations, and alcohol is not considered medically valuable.

5. Inappropriate behavior when drinking (aggression, violence, overt sexuality) is absolutely disapproved, and protection against such behavior is offered by the "sober" or the less intoxicated. This general acceptance of a concept of restraint usually indicates that drinking is only one of many activities, that it carries a relatively low level of emotionalism, and that it is not associated with a male or female "rite of passage" or sense of superiority.

Third, many of the anthropologists who have observed the behavior of distant primitive groups have discovered high correlations between most of these five conditions and low rates of alcoholism and drunkenness. For example, in 1943, D. Horton, who studied alcohol consumption in fifty- six primitive groups, reported the existence of consistent correlations between controlled drinking patterns and the maintenance of steady, ritualized tribal customs, as well as the breakdown of such moderate patterns at the interface between the primitive culture and more developed cultures.

Anthropologists have found that the advent of mechanization has brought a drastic change in the beliefs, behaviors, and rituals associated with alcohol use. Primitive cultures, rather like the American colonial culture, prepare their own alcoholic beverages and consume them in family, cross-sex, and cross-generational groups on ritual occasions with food and with a strong proscription against violence. But after machines are introduced, the men often go out to work, buy and consume commercially produced alcohol, and

drink only with other men or with prostitutes in an atmosphere that encourages unruly behavior if not violence. Under these changed circumstances drinking habits that have been moderate quickly change and become uncontrollable.

The three factors which R. Freed Bales proposed in 1944 and 1945 as contributing to the incidence of alcohol use in a given society may also be applied to the changing situation in these primitive cultures. According to Bales, the three crucial factors are the amount of inner stress and anxiety, the degree to which the culture provides alternatives, and the group's continuing attitudes toward alcohol. These anthropological studies of primitive cultures undergoing mechanization reveal all three of Bales’s factors. Other anthropological studies show that those cultures which continue to associate alcohol use with a male “coming of age” ritual, especially when the amount consumed by youths is viewed as a measure of manhood or power, are negatively correlated with “successful” or controlled drinking practices.

Fourth, in addition to the anthropological examinations of relatively underdeveloped societies, sociological studies of European and Americanized groups provide direct evidence of the influence of ethnic attitudes and socialization practices upon rates of alcoholism. The Jews have been closely studied because of their legendary low rates of alcoholism. And indeed Jewish alcohol socialization practices virtually duplicate the five conditions that are

correlated cross-culturally with nonabusive drinking patterns and low rates of alcoholism. Alcohol use is introduced early in life but is closely related to ritual feasting. Its use is consistently cross-generational and cross-sexual, and untoward or violent behavior is absolutely proscribed.

Sociologists frequently contrast the Jews with the Irish, who in America have the highest rates of both alcoholism and abstinence, indicating an initial lack of interest in moderation. Irish men frequently prefer to drink together, excluding women. They put little emphasis on eating while drinking, sometimes equate quantity of consumption with strength or manliness, and their troubled political history exemplifies the association of alcohol with violence.

The abundance of well-correlated predictions of alcohol rates based on ethnic variations in socialization evidently supports a sociocultural view of alcoholism and challenges all-out adherence to the biomedical and genetic theories. But selecting the best model of alcoholism is not so simple. A few long-range studies and many retrospective studies of family patterns of alcoholism suggest the existence of what could be called either social learning or early identification. For example, J. R. MacKay (1961) in a study of alcoholism among youth found that the largest portion of his sample had alcoholic fathers and that the sons' drinking patterns closely imitated their fathers' patterns even down to specific details. Other studies have supported

these findings of "familial tendencies" toward alcoholism that cut across ethnic groupings and are not explicable by either sociocultural or genetic theories alone.

Fifth, the efforts of economists to draw usable correlations between poverty and unemployment and the prevalence of problem drinking and alcoholism should not be minimized. Pearlin and Radabaugh (1976) specifically found an "interlocking set of economic, social and psychological conditions that both contribute to the arousal of anxiety and channel behavior to drinking as a means of coping with it." The St. Louis studies by Robins et al. (1962) of the drinking behavior of low-skilled, working- class youths, particularly black males, who had been consistently unemployed from eighteen to twenty-five indicate in a frightening way an unmistakable link between poverty, the inability to find work, and incipient alcoholism.

All of these psychosocial factors can operate at some time or other, with one individual or another, as significant precipitants for destructive drinking behavior. By contrast, factors that operate to prevent such declines are more difficult to specify. Just how our culture translates into specific social sanctions and rituals the five precepts that effectively modify potentially destructive use of alcohol has been discussed in a paper by Zinberg and Fraser (1979).

Since the repeal of prohibition, such precepts as “Know your limit,” “It is unseemly to be drunk,” and “It’s O.K. to have a few beers on the way home from work or in front of the TV but don’t drink on the job” seem to have had an effect. The consumption of hard liquor has been reduced by about 15 percent as purchases have shifted from 100-proof whiskey to 80- or 86-proof vodka, scotch, and blends. Also, and perhaps more significant, the consumption of beer and wine has increased enormously. A great deal of it is drunk while eating and in groups mixed in both sex and age. The acceptance of moderating social sanctions has led also to a fading out of the belief that high alcohol consumption indicates strength and to a decline in the acceptance of alcohol rowdiness as mere playfulness.

These changes toward moderation carry with them the necessity to condone drinking when the precepts are followed. In the often heard invitation “Let’s have a drink,” the use of the singular “a drink” encourages conviviality but specifies a limit. It is a far cry from “Let's go out and get drunk.” At the same time, the view that social controls over alcohol use in the United States are actively promoting moderation should not be accepted overoptimistically. While it is likely that fewer people are drinking hard liquor, it is also likely that drinking starts at an earlier age and that the use of alcohol in combination with a wide variety of other drugs, such as marijuana and cocaine, is far more frequent. Nevertheless, the increasing interest in the psychosocial model of alcoholism, including the development of controlling

sanctions and rituals, shows a marked advance beyond the mentality that led to prohibition, which Richard Hofstadter, in the preface to *Prohibition: The Era of Excess* (Sinclair, 1962), describes as “the incredibly naive effort to fix a ban on drinking into the Constitution itself as a final assertion of the rural Protestant mind against the urban and polyglot culture that had emerged at the end of the nineteenth and the beginning of the twentieth centuries.”

Case Studies

All three models of alcoholism—medical, genetic, and psychosocial—have validity and usefulness. They help the clinician distinguish between heavy drinkers and alcoholics, and they offer him or her a choice of perspectives from which to view each alcoholic’s problem, determine its causes, and evaluate the treatment strategies that are available. I believe, however, that the value of each of these models is enhanced by considering it in conjunction with the other two. Clinicians need the insights provided by all the models in order to deal effectively with the great variety of problem drinkers who are seeking aid. And further, we have found that this combined or multivariate model must be viewed against the background of the drinker's immediate social setting: the attitudes and behavior patterns of his family, group, and culture.

The three case studies that follow illustrate some of the possible

behavior patterns of alcoholics, some of the causal factors underlying alcoholism, and some of the methods of treating it. They also show that it is not always easy to distinguish between alcoholism on the one hand and heavy drinking on the other.

CASE 1

Robert W. is a thirty-two-year-old, white, Irish Catholic male who has been an avid A.A. member for almost five years and works as an alcohol counselor. He stands 6 feet 4 inches, weighs 210 pounds, and is the picture of health. After even a brief conversation Robert (or Bob) makes it clear that he was not always in such good shape and readily goes into his alcohol history.

Both his father and his father's younger brother were alcoholics. The screaming fights between his father and mother, an abstemious woman, over drinking are among Bob's earliest consistent memories. Interestingly enough, his only sibling is a sister two years younger than he who drinks very moderately and has little recall of this struggle, which Bob sees as dominating his childhood. From his early childhood his mother implored him never to drink, and he did not until he was almost fifteen, one or two years later than most of his peers. The very first time he gave in to his friends' teasing and shared a case of beer with them at the beach, he loved it. That night, he was told later, he drank almost the whole case, became argumentative and almost violent, proclaimed what a good time he was having, and awoke the next day remembering almost nothing about the evening before.

The experience frightened him. He swore never to drink again and thanked God that his mother had not seen him drunk. This resolution lasted almost two months, after which he indulged in a virtual repeat of the first episode. For the next two years or so he drank about once a week, always getting blind drunk and never remembering much of what happened. During this period he continued to do well at school and was the star of the basketball team. His relationship

with his mother had turned sour, however; she complained about his drinking constantly, and he bitterly resented these recriminations, claiming he was only having “a little fun.”

By his senior year in high school his drinking had increased so much that his basketball coach spoke to him about showing up for practice with alcohol on his breath and eventually benched him. This public humiliation made him even more bitter, and his expressions of those feelings resulted in the withdrawal of an offer of a basketball scholarship at a good college. (For years Bob claimed that he himself had decided against continuing his education beyond high school.)

He managed to graduate from high school despite the deterioration of his academic record. By this time he and his mother did little but scream at each other, and he was determined to move out as soon as possible. One of the most astonishing things about that whole period was that his father never mentioned Bob's drinking. Bob got a job with an insurance company which he rather liked and moved into a small apartment. There was a company basketball team, and he again starred. He began to date a young woman who worked for the same company. During this period of relative tranquility his drinking subsided to approximately one bout a week, and he convinced himself that he was in control of his life and his drinking. In fact, he recalls telling his girlfriend and others how worried he had been about his drinking, although he does not recall actually being worried, only angry when the drinking was at its height.

Every once in a while his drinking escalated, but he responded to his girlfriend’s criticisms by curbing the intensity of his bouts. A year and a half went by in this way. When both were twenty-one, his girlfriend wanted to get married, but Bob wanted to hold off and save some money. He had reestablished relationships with his family; his girlfriend had become particularly friendly with his sister, and to his great surprise his father had “gone on the wagon. ” When he was twenty-two, his girlfriend broke with him. She claimed that she had warned him repeatedly about his drinking bouts, which he saw as minimal, and she said that because of his preoccupation with basketball and drinking she had gradually stopped loving him.

This disappointment, which came as a great shock, sent him into a frenzy. He pleaded with her, threatened, and promised everything. She told him to give up drink and get back in touch with her after a year. He swore to do so and indeed abstained for six months before he heard that she had become engaged to another man. By then he was over the worst of his disappointment. He began drinking again, but moderately, and resolved to prove to that girl what a great mistake she had made. Within six months he was drinking as heavily as he had in high school. Within a year he was fired, and in the following year he lost three more jobs.

By that time he was drinking more than a quart of hard liquor a day. rarely eating, and living on the street. It was a rapid fall from grace. The occasional day-labor jobs he got only enabled him to buy cheap wine. In the ensuing three years he was detoxified some ten to fifteen times—he doesn’t remember how often or where—but he was thrown out of a dozen halfway houses for drinking and was known as an unpleasant disrupter of many A. A. meetings because of his size and strength. He also was arrested several times for drunkenness, assault, and petty thievery. Brief periods in the hospital or in jail were his only times of sobriety.

It was during one of those periods of detoxification when he was attending a compulsory A.A. meeting that he “got the message.” Something clicked, he says, and he hasn't touched alcohol since. His devotion to A.A. is enormous. After five years he still attends several meetings a week beyond those required by his counseling job.

He is doing well at work and is respected by his colleagues despite a strong argumentative streak which may cause him to change jobs shortly, but his life otherwise is not a bed of roses. Four years ago he married a black woman, also A. A., three years his junior. They have a two-year-old child and a small house in a suburb. The marriage is in serious trouble, and Bob is currently living in a room near his job. His wife objects to his temper and his lack of interest in anything but A.A. After a period of reconciliation, he is again fighting with his parental family, particularly his sister and her husband, over a blighted business deal.

Bob is proud of the fact that he has not drunk during these five troubled years, but he

refuses to become complacent and quotes the A.A. line that one can never be sure that "the Demon" is licked. His degree of insight into his own rage and stubborn passivity is mixed with considerable denial of his part in his troubles, and his tendency to blame the woman (mother, sister, former girlfriend, wife) still remains uppermost in many of his conversations.

CASE 2

Jonathan C. is a thirty-five-year-old, Jewish associate professor of sociology at a prominent university, with a pregnant wife and a son of three. As the middle child of a busy physician father and an antique-dealer mother, Jonathan always did well at school and was generally seen as a quiet but tenacious child who kept to himself and was not close to either his older sister or his younger brother.

Until his third year at college Jonathan was distinguished only by his studiousness and his steadfast avoidance of frequent dating or drinking parties. At that time he moved off campus into an apartment with three classmates who were considerably more active socially. During that year he began to date more and drink more at parties. However, on only two occasions did he get very drunk. Each time he threw up for hours and felt awful the next day. During his senior year and his first year in graduate school, he continued to "party" now and then but did not have another episode of drunkenness.

After two years of graduate school Jonathan found himself racked with indecision about his dissertation subject. Acting on the advice of his father, he found a job at a small, isolated, private secondary school teaching social studies and history. At first he liked the job very much, but by the winter he began to feel confined, restless, and resentful of his often unmotivated students. He became increasingly friendly with two other teachers who. he discovered with surprise, were homosexuals. They had other friends in the area, also homosexual, with whom Jonathan began to spend most of his time listening to music, talking, and doing amateur theatricals.

This group drank heavily and Jonathan drank with them, at first only on weekends but eventually on a daily basis. In the spring, on his way home after having had a great deal to drink, Jonathan smashed his car into a telephone pole. Although he himself was only badly shaken up, his car was virtually demolished.

Until this time no one in the group had ever made a pass at him. But after the accident, when he spent a day in the infirmary being examined for possible injuries, one man with whom he had spent a lot of time came to see him and in a teasing way made an overt sexual advance. Jonathan was nonplussed and did not know how to handle the situation. He did not want to hurt the man's feelings, but he also did not want any homosexual involvement. Because there was a nurse nearby, this initial pass could be parried, but Jonathan began to worry about what would happen next.

When he left the infirmary, he avoided the group for a few weeks despite numerous phone calls, using as excuses his lack of a car and the need to prepare his students for year-end exams. During this period he felt terribly lonely and became quite depressed. The only way he could get to sleep was to have several drinks. His liquor consumption remained at over a pint of hard stuff a day. but of even more concern, now he was drinking by himself. He invariably had a headache each morning, and his work suffered.

He began to regret his decision to return to the school the following year, but as he still had no idea what he wanted to do, he felt he had no alternative. The headmaster commented in his year-end evaluation on the slackening of Jonathan's enthusiasm after a good start and indicated his hope that the next year would be better. Jonathan spent the summer at the family beach house trying to develop a project for his thesis. He dated some, felt unsuccessful with women, and continued to be extremely depressed. Despite great difficulty in sleeping, however, he drank much less.

Shortly after his return to his teaching post, he again began to feel restless and resentful and took up with the same group. He tried to avoid the man who had accosted him sexually and

as a result no longer felt comfortable in the group. His drinking increased sharply both when with them and when alone, until he was drinking a fifth a day. Just before the Christmas holiday he skidded on an icy road when drunk and smashed up another car. This time he broke his dominant right arm and several ribs, and was badly bruised. He was also sharply taken to task by the headmaster.

Upon his return from Christmas holiday, he continued to drink and the headmaster told him not to return for the second term. At this point, for the first time, his parents became aware of his difficulties. Jonathan told them that he was an alcoholic. They previously had accepted his explanation of bad luck about the accidents. Although his father was extremely antagonistic to psychiatry, he now urged Jonathan to consult a psychiatrist. Jonathan agreed with great relief.

The consultation revealed long-standing conflicts about his sexual preference, conflicts that he had tried to deal with by avoidance. The same ambivalence had crept into his work and kept him from being able to decide about almost anything. Jonathan began an intensive psychiatric treatment subsidized by his father. The course was stormy with long periods of depression and many fights with his father, who for a long time saw too few results for too much money. Jonathan did return to graduate school, however, and after a protracted struggle finished his thesis. At no point during these difficult years and up to the present has Jonathan engaged in anything more than moderate social drinking.

CASE 3

Mark N. is a forty-seven-year-old Protestant accountant, the only child of a doting, domineering, and wealthy mother and an ineffectual, passive father, both of whom were abstemious. Spurred on by an early determination to be different from his father. Mark always did well at school and worked exceedingly hard in business. Although he appeared lively and gregarious, he had few if any really close friends. A year after becoming a certified public accountant, he married a young woman from another city whom he had known only on

weekends. She came from what appeared to be a conventional well-to-do family, but shortly after the marriage it became clear that her father, whom Mark liked enormously, led a separate life with a succession of mistresses. Mark couldn't stand her mother and brother, with whom she was close. This considerable area of conflict about her family did not prevent them from having three children in the first six years of marriage. The children are now seventeen, fifteen, and fourteen.

Until the early years of his marriage, Mark had been a moderate drinker, close to the mold of his parents. After five years of marriage he was having a drink or two every evening with his wife upon returning home from work, and he drank regularly at social events. This was a distinctly different pattern from his parents', but it was quite typical of his social group. For the next six years his life's course remained relatively stable. Periods of intense, almost overwhelming work alternated with periods of only average labor. Mark was successful and began to collect some of his fees by participating as a partner in the businesses he serviced. His marriage was acrimonious but more or less stable, though his sexual relationship with his wife began to decline chiefly because, as he claimed, overwork left him too exhausted. They became friendly with two other couples, who took the lead in actively planning outings and joint vacations, and whose marriages were similarly socially proper but personally unsatisfactory.

Just when things began to change is hard to specify. One couple got divorced. A few months later, almost exactly on Mark’s fortieth birthday, the husband of the other couple, who was a few years older than Mark, had a massive coronary and died suddenly. In retrospect Mark feels that those two events were significant if not crucial factors in his personal deterioration. He was deprived of two male friends who may have been the closest he ever had, and the divorce stimulated his wife to more open expression of her dissatisfaction with him and their marriage. Mark no longer felt part of a stable social group upon whose leadership and mores he could depend.

As the fights with his wife escalated in frequency and bitterness, Mark began to stay downtown for dinner more and more often. The companions available to him there tended to be hard-drinking, usually divorced, and were business associates or competitors. These evenings

were tense and full of discussion about deals which involved larger and larger sums of money. The alcohol Mark drank reduced his anxiety, and he thought at that time that he was thinking and planning more clearly than he ever had in his life.

His drinking escalated sharply, so that soon he was drinking heavily not only downtown but at home when faced with his wife and children. Several times at social events he got so drunk that he passed out in public, to the intense humiliation of his wife. His work pattern shifted to accommodate his drinking. He got up early, went to his office, and attended to the most pressing and urgent matters. Lunch, which was almost entirely liquid (alcohol), marked the start of drinking for the day. There would be further occasional nips during the afternoon with heavy continuous drinking after nightfall. Remarkably, during this period Mark managed to get enough work done to keep his business flourishing, but he could not take care of anything else. He completely neglected himself, making but not keeping dental and medical appointments. He rarely bought clothing, so that he began to look seedy. He abandoned even the minimum of social commitments: missing outings and rituals with his children, forgetting to send bills for services, and finally neglecting to file his federal and state income tax returns. Somewhere within the alcoholic fog that covered his day. he knew what was happening and each day planned to take care of these pressing matters. But time had the funny habit of vanishing; he had all he could do to take care of his most urgent business matters.

Mark had numerous automobile accidents, most of a minor variety, such as sideswiping a parked car on a narrow street leading to his house, but several more serious. Twice his license was suspended for drunken driving, but on each occasion, with the aid of political acquaintances, he had the suspension reduced and got his license back in a short time. All sexual relationships with his wife ceased, and in fact the two had little to do with each other after he once became violently vituperative toward her mother when he was drunk.

Three months ago everything in Mark's world collapsed. He was indicted for failure to file U.S. and state income tax returns for the previous five years, his license as a certified public accountant was suspended, and his wife forced him out of the house and sued for a divorce. Upon

the advice of his lawyer he went to a hospital to be detoxified and stayed two additional weeks for further drying out. Since then he has not returned to drinking but looks unfit physically and is extremely depressed. Perhaps of even more concern is his attitude. Several attempts to get him to attend A. A. meetings have aroused nothing but intense opposition. He sees himself as different from those "drunks" largely because he has been able to work and make money throughout his period of drinking. (This, ironically, was one of the chief points used by the prosecutor in the income tax case against Mark's plea that the alcoholism prevented him from filing.) In fact, at times. Mark can now convince himself that his wife was responsible for his drinking and that without her he could handle alcohol. He will admit that he is extremely neurotic in his relationships with women and is willing to see a psychiatrist. And, finally, after a short period in which he attempted to form a social group around two or three people whom he had met while being detoxified (who were involved in A.A.), he has returned to depending socially on his hard-drinking business acquaintances, who tease him about his enormous consumption of soda water.

Discussion of the Cases

In order to analyze effectively the cases of Robert W., Jonathan C., and Mark N., the clinician must keep in mind all three of the current models of alcoholism—the medical or biomedical, the genetic, and the psychosocial. Of course, this use of etiological models to devise treatment strategies is not new. For many decades, as H. C. Solomon pointed out in 1962, professionals in the field have been weighing the current assertions concerning the etiology of alcoholism and attempting to develop these assertions into treatment programs. Late in the nineteenth century they developed the asylum movement, while in the early twentieth century they based their strategies on

neurophysiology, biochemistry, and protein metabolism. In the mid-twentieth century their modes of treatment rested on dynamic psychoanalytic theories, and now in the latter part of the century they have turned to straight behavioral models.

I, on the other hand, propose the adoption of a comprehensive or multivariate model similar to Keller's (1973):

> This comprehensive conception takes into account not only the possible genetic, pharmacological, psychological, and social factors but also the sociocultural context. It recognizes that the society defines and labels the phenomenon of alcoholism, that the culture contributes to its development or inhibition, and that behavior that in one culture matches an adequate rational definition of alcoholism may not constitute alcoholism in another. Thus, periodic intoxication causing sickness for several days and necessitating absence from work may define alcoholism in a modem industrial community but, in a rural Andean society, periodic drunkenness at appointed communal fiestas, resulting in sickness and suspension of work for several days, is normal behavior. An essential aspect of the difference is that drunkenness at fiestas is not individually deviant behavior.

Our model, though, is broader than Keller's, and it gives the social factors more prominence. It includes all the applicable biomedical factors, all the possible genetic factors suggested by the Danish twin studies, and all the psychosocial factors—individual, family, group, and cultural—that lay the foundation for alcoholism. Many psychosocial conditions may pave the way for vulnerability to alcohol: lack of parental care and affection, overindulgence, or inconsistency in child-rearing practices during infancy and

early childhood; certain family and ethnic responses to alcohol; and the lack of consistent, coherent social sanctions and rituals that condone moderate alcohol use and prevent alcohol abuse. It is clear that under certain conditions, both psychological and social, a vulnerable individual may learn to react to difficulties by resorting to intoxication. Whether psychological or social, this vulnerability is a matter of degree. A more vulnerable person may find prominent rewards in alcohol regardless of social strictures, while a less vulnerable person may succumb only in a social milieu that permits or encourages heavy drinking and intoxication.

While we believe that the comprehensive model provides the best understanding of all the factors involved in the development and operation of alcoholism, we also recognize that its very inclusiveness forces the clinician to choose among many different treatment strategies instead of simply, for example, recommending abstinence, the treatment prescribed by the genetic model, or drugs, which would be prescribed by a strict medical model. The cases of Robert W., Jonathan C., and Mark N. illustrate this difficulty.

Robert W. is the classic alcoholic. He has a strong family history of alcoholism and a personal history of drinking alcoholically—that is, in order to get drunk—with all the blackouts, unruly behavior, and denial of the import of drinking that alcoholism includes. He believes, and few experienced observers would disagree with him, that he can never drink again. A single

drink would be the beginning of a binge despite his years of sobriety and his pride in what he has accomplished since becoming sober.

Growing up with an alcoholic father and a mother preoccupied with her terror of alcoholism certainly could be seen as early developmental factors that might lead to psychological conflict. And Bob's situation at present indicates that although the curse of drinking has been lifted and he has a steady job that he likes and is good at, he still has a number of serious interpersonal conflicts that cause trouble. It is hard, however, to make any direct links between these psychological difficulties and his drinking or, indeed, his abstinence.

It is true that his early drinking education outside the family as well as in his ethnic background neglected many of the principles that lead to the social sanctions which support controlled drinking. His peer group did not clearly differentiate group drinking from drunkenness; they purposely drank as a unigenerational group of males even though it caused them some embarrassment to exclude women and other generations. Their drinking was not associated with any sort of ritual feasting and generally not with eating. They drank to “have a good time,” which for them included escaping from the rigors of unsatisfactory work, difficult interpersonal relationships, and demanding women. Finally, both the extent of their alcohol consumption and their aggressive and belligerent behavior were aggrandized and accepted as

measures of manliness.

Only quite late in Bob's drinking career, when he was already a serious alcoholic, did his peer group register disapproval of his drinking by suggesting that he cut it down. In retrospect Bob realizes that he was acquainted with the usual cultural sanctions about drinking—"Don't drink on the job"; "Drink to be sociable and not to get drunk"; "Don't drink alone"; "Falling down drunk looks awful"—but he insists that at no time were such sanctions really meaningful to him. Although he experienced considerable shame and guilt about what his drinking was doing to him and especially to others, the conventional stereotypes about controlled drinking meant little to him because drinking was too precious to be qualified or moderated. He loved it and now he is willing (just barely, he says) to lose it, but he could not bear "playing games" with it, which is his way of looking at control mechanisms.

The case of Jonathan C. is vastly different. Here it is a question of whether alcoholism is indeed the issue. Although he went through a period of extremely heavy drinking that resulted in automobile accidents and job loss, damaging his capacity to function effectively, to get along with people, and to maintain his health, it is doubtful that such a sharply encapsulated drinking period can properly be called alcoholism. At the same time, the criteria for alcoholism proposed by such an authority as Cahalan (Cahalan et al., 1969; Cahalan and Room, 1974) can be met by Jonathan, and, interestingly enough,

he thought of himself as an alcoholic.

But there is nothing in his history that would indicate alcoholism. There are no known hereditary, familial, or ethnic vulnerabilities. And in his case the knowledge and acceptance of social sanctions concerning drinking were conscious and well integrated. The fear that his friends (other than his drinking group) or his family would see him drunk was strong, and the accompanying guilt about his behavior was sharp and painful. Generally speaking, Jonathan believed in drinking as relaxation but not to get drunk, preferred to drink in mixed company, did not believe it manly to drink a lot, and did not become aggressive under the influence of alcohol.

Nevertheless, it became clear after Jonathan's year of heavy drinking when he was a secondary school teacher that he had deep-rooted and serious unconscious conflicts around his sexual identity. Not only did he attach himself to a social group that was less concerned than he with the principles sanctioning moderate drinking, but he chose a group that triggered his most painful and unacceptable wishes. It would not be going too far to describe Jonathan as being in a homosexual panic at that time. He could neither accept his homosexual wishes and interests nor detach himself from the stimulating interactions of that particular social situation.

The combination of severe internal conflict and lack of controlling social

sanctions and rituals allowed alcohol, with its potential for amnesia and its tranquilizing qualities, to become Jonathan’s escape route. He could not of himself decide to seek out a psychiatrist because that came too close to acknowledging the unthinkable—his forbidden homosexual wishes. But once an outside agent, his father, had virtually made the decision, he could gratefully accept it, just as he had when the headmaster by firing him had separated him from the social group that he secretly wanted to leave.

It is very questionable whether Jonathan could be classified as an alcoholic, but even if he were so classified, his alcoholism would be quite different from Bob’s. In Jonathan’s case the psychological strains leading to drinking were clear-cut, and once these were made conscious, the pressure to drink receded. Jonathan reverted to his usual acceptance of social sanctions against excessive drinking and returned to social groups that supported and reinforced those sanctions.

Mark N. provides still another perspective on alcoholism. Here, as with Jonathan, there are no obvious genetic, ethnic, or family vulnerabilities to alcoholism, but there are indications of lifelong psychological difficulties. A doting, controlling mother and a father who is seen as a failure; a longing for male friends but little talent for making such friends; and a hostile, dependent relationship with women (the case history does not include his twelve-year relationship with his secretary, which in most details was a recapitulation of

his relationship with his wife)—all these factors coalesce to form the classical neurotic picture.

Such a picture indicates potential vulnerability to almost any serious psychological symptom. But did it lead directly to Mark’s drinking, as was suspected in the case of Jonathan? That point seems far less clear. The loss by divorce and death of his two closest men friends seems to have forced Mark further into the intolerable relationship with his wife. After the disappearance of his old friends, he chose a new social group that offered him an escape and at the same time shared his business interests, thus serving both his self-esteem and his wish for isolating mechanisms. Was it simply fortuity that his new companions were hard drinkers, or did Mark seek them out for that reason? It is difficult to know. Nevertheless, it is unlikely that he himself would have led others into heavy drinking, and for a long period, at least, he was not a lone drinker.

In Mark’s family background there had been little opportunity to learn and integrate social sanctions that condoned controlled drinking. His parents, his mother in particular, regarded intoxication and excessive social drinking as morally wrong and somehow vulgar. Throughout his youth he had accepted those precepts and avoided situations that would conflict with them. It was only after marriage and exposure to his wife’s family that he took social risks for which he was unprepared.

There is little doubt that Mark is an alcoholic. Just as Jonathan has tried to deny his painful, destructive sexual conflict by seeing himself as an alcoholic, so Mark tries to deny his alcoholism by seeing himself as a neurotic. Neither can bear the idea that he is unable to deal with certain social functions that most other people can handle. In Jonathan's case it has been important to accept the drinking as merely a symptom and attempt to get around his denial of underlying sexual anxieties. In Mark's case, however, to treat the alcoholism only as a symptom of his obvious psychological problems might cause him to continue his self-destructive drinking while "waiting" for the resolution of underlying conflicts to do away with his wish to drink. This type of treatment would obviously be nonsense: few therapists would go on treating psychologically an alcoholic patient who was continuing to drink. But many would see the drinking as a symptom that interfered with the treatment instead of as a well-developed "disease" entity, whatever the original etiology. In such a case some therapists might find abstinence essential during treatment, but they might also expect that after treatment had succeeded, the patient would be able to return to controlled drinking.

This attitude raises an extremely delicate problem that is related to the essential issue of discriminating between the alcoholic and the heavy drinker. Our reviews of the etiological models of alcoholism as well as our case studies indicate that a different etiology or combination of etiologies is at work in each specific case. Yet despite this variety of cases and causes, A.A., which

offers by far the most successful mode of therapy, always prescribes the same method of treatment. A.A., in fact, goes so far as to develop a tautology: any "alcoholic" who successfully returns to controlled drinking was not an alcoholic in the first place. This outlook lumps the long-term alcoholic—one, for example, whose service career was interrupted thirty years ago because of alcoholic excess and whose life now revolves around a quart of cheap muscatel—with the young executive who has resorted to a $30 weekly scotch expenditure since his promotion into a hard-driving office circle. Such an outlook leaves A. A. successful in treating the first type of case but may interfere with its capacity to intervene early and act preventively in the second.

The prescription of abstinence would most certainly apply in Bob's case, where early and powerful psychosocial determinants (cultural and family) pointed specifically to alcoholism. Even the possible existence of a genetic determinant of alcoholism could not be ruled out in his case. The genetic model, which roughly equates drinkers who have a constitution vulnerable to alcohol with those who are allergic to penicillin, rightly includes the prescription for abstinence.

Another group of individuals unlikely to be able to drink again includes those who have been attached to the bottle for many years and have lost their capacity to function socially, psychologically, and even physically. It matters

little whether their years of alcoholism have brought about a metabolic or other physiological change, whether psychological deterioration and sensitization to the alcohol experience have occurred, whether the learned behavior precipitated by alcohol use has led to drunkenness, or whether the ability to use social sanctions and rituals for purposes of control has been totally and irrevocably lost. The profound experience of long-term alcoholic deterioration seems to rule out further contact with alcohol.

But certain other cases are less clear-cut. Had Jonathan, by some definitions an alcoholic, been seen by some clinicians during the fall of his second teaching year, they might have prescribed lifelong abstinence, which in retrospect would have been a mistake. The jury is still out on Mark N. on several counts. The attempt of Mark's psychological treatment to work through his problems with women may be of lesser importance in the long run than his return to a hard-drinking social group. An experienced observer cannot help sensing that Mark is not yet through his run with alcohol. So far it is impossible to tell to what extent his drinking stemmed from psychological vulnerability and to what extent it resulted from the breakdown of social groups on whom he depended for the moderating social sanctions and rituals that were missing in his home.

It is our contention that consideration of the social context in which the drinker lives must go beyond attempting to separate out etiological factors in

order to determine whether the prescription is abstinence or a return to controlled drinking. Indeed, we are convinced that in many cases the social context of drinking itself may provide the critical etiological variable. It is obvious, for example, that when the developed social sanctions and rituals break down, loss of control results; and if that breakdown can be established as the essential factor leading to alcoholism, it must be specifically taken into account when deciding upon a treatment regimen, especially if some treatment other than abstinence is being considered.

But whether the clinician considers the breakdown of the social context to be of direct causal significance, or believes that early psychological problems are crucial, or finds the impact of family or genetic predilections to drinking uppermost, or sees the difficulty as a learned disability, all drinking occurs in a social context. And as American social history shows, the capacity of the existing social sanctions and rituals to control alcohol use varies from one period to another. Because these social factors set the boundaries within which people drink, they affect how people drink and the extent to which they drink. Even those who must remain abstinent live in a social context that either helps or hinders their efforts to abstain. It is paradoxical that the same set of social controls (sanctions and rituals) that is crucial to the promotion of controlled drinking and thus the prevention of abuse, or alcoholism, is not effective in the prevention of use, or abstinence. In American society, which condones drinking and has gradually developed sanctions and rituals that

encourage moderate use of alcohol, the kinds of sanctions and rituals necessary to prevent all alcohol use can only be maintained by a small, cohesive, and, in the case of A.A., desperate community willing to erect specific social barriers to separate itself from the larger society. In this modem, heterogeneous, pluralistic nation the attempt to impose abstinence through legislation has proved a miserable failure.

Our comprehensive or multivariate model of alcoholism encompasses a series of interlinked etiological factors, one or more of which are predominant in specific cases but all of which exist within either a limiting or an expanding social setting. So far, clinicians have tended to develop treatment strategies and overall ways of looking at the patient's problems and attitudes by focusing on the predominant etiological factors. They have seen the social context, including both the larger society's attitude toward intoxicants and the patient's social group situation, as ancillary, almost as a necessary nuisance, rather than as a critical determinant of the patient's situation regardless of the more specific etiology.

Depending on the way in which they have interpreted their patients' histories, therapists have usually suggested that patients try psychotherapy or drugs or self-help groups. Because few histories have specified the relationship of the patient to his social context, few therapists have taken that relationship into account. True, this narrower approach has often worked out.

Bob's referral to A.A. was correct and so was Jonathan's referral to a psychiatrist. But it should be pointed out that these referrals did not in fact exclude the social setting. In Bob's case. A. A. automatically prescribed a particular social context as paramount in the treatment. As it happened, Jonathan had changed his social setting just before beginning psychotherapy. It is probable that the social aspect of his case would have needed more careful attention if he had begun psychiatric treatment while still teaching at the secondary school. As for Mark, his social situation is still a problem that may require the most careful consideration if he is to remain sober. The outcome of his therapy will depend primarily on the decisions he makes in regard to his social setting: whether he changes his mind and joins A.A. or continues to socialize with his hard-drinking friends.

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Notes

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